UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

17CV 1826

RICARDO LEON JESUS

(In the space above enter the full name(s) of the plaintiff(s).)

-against-

THE CITY OF NEW YORK, P.O. MARTIN MARTINEZ, #265, P.O. ERIC TYLER-D.E.A. -N.Y.D.E.T.F. P.O. JOHN DOE, #3) P.O. JOHN DOE, #4). et.al. 52 PRECINT.

Defendant(s).

(In the space above enter the full name(s) of the defendant(s). If you cannot fit the names of all of the defendants in the space provided, please write "see attached" in the space above and attach an additional sheet of paper with the full list of names. The names listed in the above caption must be identical to those contained in Part I. Addresses should not be included here.)

COMPLAINT
under the
Civil Rights Act, 42 U.S.C. § 1983
(Prisoner Complaint)

Jury Trial: ☑ Yes ☐ No
(check one)

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I. **Parties in this complaint:**

A. List your name, identification number, and the name and address of your current place of confinement. Do the same for any additional plaintiffs named. Attach additional sheets of paper as necessary.

Plaintiff
Name RICARDO LEON JESUS,
ID # #349-16-06178
Current Institution R.N.D.C. - RIKER'S ISLAND
Address 11-11 HAZEN STREET, E.ELMHURST, NEW YORK, 11370

B. List all defendants' names, positions, places of employment, and the address where each defendant may be served. Make sure that the defendant(s) listed below are identical to those contained in the above caption. Attach additional sheets of paper as necessary.

Defendant No. 1
Name THE CITY OF NEW YORK, Shield #
Where Currently Employed
Address

Defendant No. 2 Name P.O. MARTIN MARTINEZ, #265 Shield #_____
Where Currently Employed CITY OF NEW YORK, N.Y.P.D.
Address 52nd,

Defendant No. 3 Name P.O. ERIC TYLER- .E.A. of N.Y. Shield #_____
Where Currently Employed CITY OF NEW YORK
Address 1 POLICE PLAZA-FEDERAL PLAZA

Defendant No. 4 Name _____ Shield #_____
Where Currently Employed _____
Address _____

Defendant No. 5 Name _____ Shield #_____
Where Currently Employed _____
Address _____

II. Statement of Claim:

State as briefly as possible the facts of your case. Describe how each of the defendants named in the caption of this complaint is involved in this action, along with the dates and locations of all relevant events. You may wish to include further details such as the names of other persons involved in the events giving rise to your claims. Do not cite any cases or statutes. If you intend to allege a number of related claims, number and set forth each claim in a separate paragraph. Attach additional sheets of paper as necessary.

A. In what institution did the events giving rise to your claim(s) occur?

~~NON-APPLICABLE.~~ - SEE ATTACHED STATEMENT

B. Where in the institution did the events giving rise to your claim(s) occur?

~~NON-APPLICABLE.~~ SEE ATTACHED STATEMENT

C. What date and approximate time did the events giving rise to your claim(s) occur?

~~NON-APPLICABLE.~~ - SEE ATTACHED STATEMENT.

D. Facts: (SEE, ATTACHED STATEMENT OF FACT'S)

What happened to you?

Who did what?

Was anyone else involved?

Who else saw what happened?

III. Injuries:

If you sustained injuries related to the events alleged above, describe them and state what medical treatment, if any, you required and received.

IV. Exhaustion of Administrative Remedies:

The Prison Litigation Reform Act ("PLRA"), 42 U.S.C. § 1997e(a), requires that "[n]o action shall be brought with respect to prison conditions under section 1983 of this title, or any other Federal law, by a prisoner confined in any jail, prison, or other correctional facility until such administrative remedies as are available are exhausted." Administrative remedies are also known as grievance procedures.

A. Did your claim(s) arise while you were confined in a jail, prison, or other correctional facility?

Yes ___ No ___

"STATEMENT OF FACT'S"

#1.) On or about the 25th,day of May,2016 at approxiametly 7:10 p.m. in the county of the bronx,new york plaintiff was accosted by several law enforcements under cover agents in plain clothings from the Federal Task Force of Drug Enforcement Agency-N.Y.-D E.T.F. unit by special agent"ERIC TYLER" and his detailed security personell.

#2.) Plaintiff was falsely accused to been in possesion of concealed contraband items in violation of penal law§220.21 and 220.16(1). plaintiff is alleged to been observed on the street of East 191 Street,and Morris Avenue while in alleged possesion although the alleged bag carrying such items was obstructed by colorful shade the belief that plaintiff was in possesion came from a unnamed pepson or informant known to the prosecutor had conveyed this information to a subsequent police officer from the N.Y.P.D. of

"Continuation"

the #2nd precint statio house area name #etective MARTIN MARTINEZ, Shield#265 of the assigned Drug Enforcement Task #orce.Who became the arresting police official in the arrest and injury liability.

#3.) Plaintiff was approach by several officer's from the Task Force unit who negated to identify themselves as Police Officials when they encountered him,plaintiff was approached in a extreme violent and aggresive manner which struct fright in him to believe he was about to be assaulted # Robbed by the group of officers and began run for his safety.Next,plaintiff was chase and soon caught during such time he was immediately shoved to the pavement ground and beat upon by all the arriving police officers in the unit group.Plaintiff never resisted arrest and remain upon the pavement curled up as each police officer continuied to commence a unwarranted severe assault upon him.

#4.) Plaintiff was assaulted while he was in secured hand restraints knows as hand cuffs behind his back area.As a result of this assault upon his person plaintiff was taken to BELLEVUE GENERAL HOSPITAL,for immediate treatment of medical assistance. these injuries consist of symptoms of vertigo,severe back injury trauma,

#5.) Plaintiff wrote to the New York City Civilian Complaint Reveiw Board Commission with a grievance complaint against these officers and has not received any acknowledgment as of the date of the filing of this civil complaint lawsuit.

#6.) Plaintiff thereafter confided this information to his retained criminal defense attorney Mr.TELESFORO DEL VALLE,Jr.Esq.at 445 Park Avenue,9th,Floor,New York,New York,10022 who have address

"Continuation"

that issue with the internal affairs division for the N.Y.-P.D. and is awaiting for the final outcome from that file complaint and investigation.

#7.) Plaintiff was brutally assaulted while in physical restraints handcuff behind his rear back.at the time of the assault the plaintiff had lost full consciencesness of his surroundings & enviroment. The defendants consisted of four police individuals who commence the asssault upon plaintiff on the date of May,25, 2016.

#8.) Plaintiff was eventually sent to the New York City department of corrections after being arraigned upon the alleged criminal charges upon entering the prison/facility he was given further medical treatment of medications to assist his predictiment and condition.

"LEGAL ARGUMENT"

#1.) Plaintiff contends to proffer# that the named defendants in the complaint unlawfully use excessive unnecessary force upon his person while he was in physical restriants, and had presented no apparent threat or risk to each police officer present at the time of his arrest.

#2.) There is no mistaken impression to the unconstitutional civil violations attributted by the individual defendants in this claim or action per se. Plaintiff was not an typical aggressor towards the officials or defendants and the defendants at the time of the arrest was not preventing the plaintiff from making and attempt to escaping or obstructing apprehension at that precise moment leading up to the encounter, when essentially they(defendants) had not produce or displayed any law enforcement credentials I.D. themself's as members from the authoritive government the intent

"Continuation"

#3.) and deliberate use of physical force is questioned to be excessively unjustifiable.

#4.) Plaintiff files this action under the 42 U.S.C. #1983 and 28 U.S.C. #1343,The use of force herein was completely unjustified under the proscribed circumstances plaintiff was faced with at the time of the encounter.The defendants has elected to use the mechanical metal restraints when it is considered by the department policy to be a excessive use of force device and practically unreasonable. These acts in themselves are arbitrary in nature,with punitive characteristics under the lack of probale cause to inflict such unnecessary violent misconduct upon plaintiff especially under the circumstances for which he was physically secured within the hand restraints.

Del Valle & Associates
Attorneys at Law
445 Park Avenue, 9th Floor
New York, New York 10022
(212) 481-1900

Telesforo Del Valle, Jr.
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of counsel

Email: tdvesq@aol.com
Fax: (212) 481-4853

New Jersey Office
660 Newark Avenue
Jersey City, New Jersey 07306

Robert Torres
Legal Assistant

September 1, 2016

Clinic
Robert N. Davoren Center
11-11 Hazen St, East Elmhurst, NY 11370
Tel: (718)546-7067
Fax (718)546-7028

Re: Jesus Ricardo Leon,
Book & Case No. 3491606178
NYSID: 13499354N

Dear Sir/Madam,

Our office represents Mr. Jesus Ricardo Leon, who is currently detained in your facility.

We write to you to kindly request you arrange for Mr. Jesus Ricardo Leon to receive immediate medical attention.

On May 25, 2016, after being arrested, he was taken to the Bellevue Hospital ER and was instructed to return for further symptoms and complaints. (See Discharge Report attached)

He has been having symptoms of vertigo and light headedness ever since. He was prescribed Meclizine HCL, 25 mg to prevent these symptoms, but he continues to have them and has fainted twice in your facility in the past few days.

Please arrange for Mr. Jesus Ricardo Leon to receive medical attention as soon as possible. Thank you.

Kind regards,

Telesforo Del Valle, Jr., Esq.
DEL VALLE & ASSOCIATES

Del Valle & Associates
Attorneys at Law
445 Park Avenue, 9th Floor
New York, New York 10022
(212) 481-1900

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New Jersey Office
660 Newark Avenue
Jersey City, New Jersey 07306

Robert Torres
Legal Assistant

October 4, 2016

Clinic
Robert N. Davoren Center
11-11 Hazen St, East Elmhurst, NY 11370
Tel: (718)546-7067
Fax (718)546-7028

Re: Jesus Ricardo Leon,
Book & Case No. 3491606178
NYSID: 13499354N

Dear Sir/Madam,

Our office represents Mr. Jesus Ricardo Leon, who is currently detained in your facility.

We write to you to kindly request you arrange for Mr. Jesus Ricardo Leon to receive immediate medical attention.

On May 25, 2016, after being arrested, he was taken to the Bellevue Hospital ER and was instructed to return for further symptoms and complaints. He has been having symptoms of vertigo and light headedness ever since. He was prescribed Meclizine HCL, 25 mg to prevent these symptoms, but he continues to have them and has fainted various times in your facility. The last time he fainted, on September 27, 2016, he fell and hurt his shoulder.

Please arrange for Mr. Jesus Ricardo Leon to receive medical attention as soon as possible. Thank you.

Kind regards,

Telesforo Del Valle, Jr., Esq.
DEL VALLE & ASSOCIATES

CRIMINAL COURT OF THE CITY OF NEW YORK
COUNTY OF NEW YORK

THE PEOPLE OF THE STATE OF NEW YORK

-against-

Jesus Ricardo Lucas (M 33),

Defendant

FELONY

ADA James Hanley
212-815-0173

Detective Martin Matinez, Shield 265 of the Drug Enforcement Task Force, states as follows:

The defendant is charged with:

1	PL 220.21(1)	Criminal Possession of a Controlled Substance in the First Degree (defendant #1: 1 count)
2	PL 220.16(1)	Criminal Possession of a Controlled Substance in the Third Degree (defendant #1: 1 count)

On or about May 25, 2016 at about 7:10 P.M., at the south east corner of East 170st Street & Morris Avenue in the County of Bronx and State of New York, the defendant knowingly and unlawfully possessed a substance containing a narcotic drug and said preparation, compounds, mixtures and substances are of an aggregate weight of eight ounces or more; the defendant knowingly and unlawfully possessed a narcotic drug with intent to sell it.

The factual basis for these charges are as follows:

I was conducting surveillance with respect to an ongoing investigation, and observed the defendant exit 2485 Morris Avenue, Bronx, New York carrying a white Modell's bag. I am informed that Special Agent Eric Tyler, DEA-NYDSETF, observed the defendant walking on Davidson Avenue, with the same Modell's bag which were appeared to hold a box inside. Special Agent Tyler approached the defendant and requested identification, at which time the defendant dropped the bag and ran away. The bag contained a box, which contained approximately one (1) kilogram of heroin, as well as a smaller quantity of heroin.

I believe the substance is what it is alleged to be based upon my professional training as a police officer in the identification of drugs, my prior experience as a police officer making drug arrests, an observation of the packaging, which is characteristic of this type of drug and a field test of the substance which confirmed that the substance is in fact

If YES, name the jail, prison, or other correctional facility where you were confined at the time of the events giving rise to your claim(s). "NO!"

B. Does the jail, prison or other correctional facility where your claim(s) arose have a grievance procedure?

Yes ___ No ___ Do Not Know ___ "N/A"

C. Does the grievance procedure at the jail, prison or other correctional facility where your claim(s) arose cover some or all of your claim(s)?

Yes ___ No ___ Do Not Know ___ "N/A"

If YES, which claim(s)? _____

D. Did you file a grievance in the jail, prison, or other correctional facility where your claim(s) arose?

Yes ___ No ✓

If NO, did you file a grievance about the events described in this complaint at any other jail, prison, or other correctional facility?

Yes ___ No ✓

E. If you did file a grievance, about the events described in this complaint, where did you file the grievance? "N/A"

1. Which claim(s) in this complaint did you grieve? "N/A"

2. What was the result, if any? "N/A"

3. What steps, if any, did you take to appeal that decision? Describe all efforts to appeal to the highest level of the grievance process. "N/A"

F. If you did not file a grievance:

1. If there are any reasons why you did not file a grievance, state them here: "N/A"

2. If you did not file a grievance but informed any officials of your claim, state who you informed,

when and how, and their response, if any: "N/A"

G. Please set forth any additional information that is relevant to the exhaustion of your administrative remedies. "Non-Applicable"

Note: You may attach as exhibits to this complaint any documents related to the exhaustion of your administrative remedies.

V. **Relief:**

State what you want the Court to do for you (including the amount of monetary compensation, if any, that you are seeking and the basis for such amount).

VI. **Previous lawsuits:**

On these claims

A. Have you filed other lawsuits in state or federal court dealing with the same facts involved in this action?

Yes ____ No ✓

B. If your answer to A is YES, describe each lawsuit by answering questions 1 through 7 below. (If there is more than one lawsuit, describe the additional lawsuits on another sheet of paper, using the same format.)

1. Parties to the previous lawsuit: "Non-Applicable"

Plaintiff _____

Defendants _____

2. Court (if federal court, name the district; if state court, name the county) _____

3. Docket or Index number _____

4. Name of Judge assigned to your case "Non-Applicable"

5. Approximate date of filing lawsuit _____

6. Is the case still pending? Yes ____ No ____

If NO, give the approximate date of disposition _____

7. What was the result of the case? (For example: Was the case dismissed? Was there judgment in your favor? Was the case appealed?) _____

On other claims

C. Have you filed other lawsuits in state or federal court otherwise relating to your imprisonment?

Yes ____ No ✓

D. If your answer to C is YES, describe each lawsuit by answering questions 1 through 7 below. (If there is more than one lawsuit, describe the additional lawsuits on another piece of paper, using the same format.)

1. Parties to the previous lawsuit: "Non-Applicable"

Plaintiff _____

Defendants _____

2. Court (if federal court, name the district; if state court, name the county) _____

3. Docket or Index number _____

4. Name of Judge assigned to your case _____

5. Approximate date of filing lawsuit _____

6. Is the case still pending? Yes ____ No ____

If NO, give the approximate date of disposition _____

7. What was the result of the case? (For example: Was the case dismissed? Was there judgment in your favor? Was the case appealed?) _____

I declare under penalty of perjury that the foregoing is true and correct.

Signed this 23 day of Febrero, 2017

Signature of Plaintiff Ricardo Leon, Jesus

Inmate Number #349-16-06178

Institution Address R. N. D. C
11-11 HAZEN ST
E. ELMHURST, NEW YORK
11370

Note: All plaintiffs named in the caption of the complaint must date and sign the complaint and provide their inmate numbers and addresses.

I declare under penalty of perjury that on this 23 day of Febrero, 2017 I am delivering this complaint to prison authorities to be mailed to the *Pro Se* Office of the United States District Court for the Southern District of New York.

Signature of Plaintiff: Jesus Ricardo.

Bellevue Hospital Center
462 First Avenue
New York, NY 10016

MRN:3731158
Patient:Ricardo,Jesus
DOB:10/15/1962 Sex:M Type:EP

Visit Date:05/26/16 Visit# 3731158-1
Location:emergency

Outpatient Chart Print

All Events - continued

Thu, 26May 0304 ED MD Disposition Note/Order (ED MD DisposiStatus: complete

ED Attending	: Rern Lau, MD
Provider	: Rern Lau, MD
Disposition	: Discharged to Home or Self Care
Disposition Date/Time	: Thu, 26 May 2016 0304
Primary Dx	: Essential (primary) hypertension
Secondary Dx(s)	: med clearance
Discharge Rx	: none
Focused Med Rec	: Medication Reconciliation Complete. No changes to current medications.
Condition	: Stable
Instructions for Pt	: Return for chest pain, shortness of breath or any other new or worse symptoms
Discharge Center?	: no
HIV Test Results	: no hiv test at this visit
Follow Up	: return to ED for further complaints
DC Report Language	: Spanish
Whiteboard Display	: Patient in ED. Keep/Add back on Whiteboard.
Instructions for RN	: please facilitate discharge
Med Decision Making	: I viewed EKG(s) and independently made an interpretation.
Tests Reviewed	: I have reviewed all labs, ancillary testing, and radiology resulted for this patient prior to disposition.

Rern Lau, MD (26 May 16 0305)

Documentation History	Employee	Date/Time
documented by	Sig:Lau,Rern, MD Emergency Department , Attending Physician (ESOF)	05/26/16 03:05

Thu, 26May 0321 Whiteboard Display (ED) Status: complete

Whiteboard Display	: Patient left ED. Remove from all Whiteboards.
Comment	: medically cleared and discharged by Md No IV line

Nicola Brown, RN (26 May 16 0321)

Printed:16 Dec 16 1527:50

Bellevue Hospital Center
462 First Avenue
New York, NY 10016

MRN:3731158
Patient:Ricardo,Jesus
DOB:10/15/1962 Sex:M Type:EP

Visit Date:05/26/16 Visit# 3731158-1
Location:emergency

Outpatient Chart Print

All Events

Thu, 26May 0107 ED Triage Note — Status: complete

Life Saving	: Complete Full Triage Note
Communication Method	: NYPD
Restraints	: Patient brought in to ED in handcuffs.
Mode of Arrival	: police agency
Chief Complaint	: Medical Clearance : HTN,
Assessment	: aox3, respiration spontaneous and unlabored, ambulatory
Past Medical/Surgical Hx	: htn
Medications on Arrival	: canot recall name
Allergies - Medications	: no known drug allergies
Allergies - Other	: no known allergens
Domestic Violence	: Domestic Violence: no
Psych Risk Assessment	: None indicated at this time
ED Alerts	: None; NYPD Prisoner;
Blood Pressure	: 154/85
Pulse	: 86
Respirations	: 18
Temperature	: 99.1 F (37.3 C)
Temperature Method	: Oral
O2 Saturation	: 98 %
Suspected Infection?	: no
Alteration of Mental Stat	: no
Pain Screen	: pt denies pain at this time
ESI Level	: 4
Team Assigned	: AES Team 3
Suspected Sepsis	: no
Blood/Body Fluid Exposure	: no

Sylwia Dziwirek, RN (26 May 16 0109)

Documentation History	Employee	Date/Time
documented by	Sig:Dziwirek,Sylwia, RN Nursing, Nurse - Registered (ESOF)	05/26/16 01:09

Outpatient Chart Print

All Events - continued

Thu, 26May 0119 ED RN Initial Assessment Status: complete

Vital Signs	: Vitals recently documented and reviewed
Pain Screen	: no change from last pain screen
ESI Level	: 4
Chief Complaint	: Medical Clearance : HTN,
Triage Assessment	: aox3, respiration spontaneous and unlabored, ambulatory
Pre-Hospital Tx	: None
Focused Assessment	: Pt BIB NYPD MC: HTN; Pt aox3 unlabored breathing, bilat lungs clear; denies CP Dizziness HA SOB N/V/D; responsive to all stimuli; continent of bowel and bladder; abrasion to L elbow s/p arrest; further eval from Md in progress; Pt continue to be monitored
Past Medical/Surgical Hx	: htn
Medications on Arrival	: canot recall name
Allergies - Medications	: no known drug allergies
Allergies - Other	: no known allergens
Med Allergy(ies) Document	: (Yes) Allergies reviewed or documented
Domestic Violence	: Domestic Violence: no
Psych Risk Assessment	: None indicated at this time
ED Alerts	: None; NYPD Prisoner;
HIV Test Offering	: Offered and patient declines HIV testing
Preferred Language	: Spanish
Communication Ability	: Able to communicate
Language Used	: Spanish
Interpreter Name/Modality	: staff
Suspected Sepsis	: no

Nicola Brown, RN (26 May 16 0122)

Documentation History	Employee	Date/Time
documented by	Sig:Brown,Nicola, RN Nursing, Nurse - Registered (ESOF)	05/26/16 01:22

Outpatient Chart Print

All Events - continued

Thu, 26May 0256 ED Provider Initial Note — Status: complete

Time Patient Seen	: Thu, 26 May 2016 0256
Communication Method	: Direct Communication in English
ED Attending Provider	: Rern Lau, MD
ROS	: Rern Lau, MD Review of systems negative except as below and in HPI.
Provider Note	: Patient is a 53yo man who was BIB NYPD for medical clearance because of hx HTN. No chest pain, states he felt short of breath as he was running from PD but had no other symptoms at the time, no current dyspnea or neurologic symptoms. Has longstanding hx HTN. Doesn't know his meds. Last took medication 4 days ago. Last time evaluated by MD was 3 months ago in Mexico. PMHx/meds/all per nursing PE: VS per nursing EKG NSR 90, otherwise normal see also attached physical exam A/P HTN, chronic, asymptomatic, cleared for arraignment at this time and given return precautions.
RN Note Reviewed	: I have reviewed the RN notes and documented any additions in the Provider note field.
Provider Exam	: No apparent distress. Alert and oriented X3 Well developed, well nourished. Pt has no pallor. Eye exam within normal limits. ENT exam within normal limits. Respiratory exam is within normal limits. CV exam within normal limits. GI exam within normal limits. No evidence of trauma/ facial trauma. Alert and oriented X3. Cranial nerves II - XII

NYC HEALTH+ HOSPITALS

Insurance: Self Pay

RICARDO, LEON JESUS

NYSID: 13499354N BookCase: 3491606178
Facility Code: RNDC Housing Area: 4UN
53 Y old Male, DOB: 10/15/1962
Account Number: 330345
312 E 183 ST, BRONX, NY

Appointment Facility: West Facility

08/16/2016

Appointment Provider: Olga Segal, MD

Current Medications

Taking

- Debrox 6.5 % Solution Total Dose: 10cc Every 12 Hours, stop date 08/30/2016, Drug Source: Pharmacy

Allergies

N.K.D.A.

Reason for Appointment

1. Neuro

History of Present Illness

Notes::

53yo RH Spanish-speaking HM with PMHx R-occipital trauma May 2016 with subsequent Left decreased hearing and lightheadedness, R-occipital pain, presented on 8/16/16 for initial evaluation of lightheadedness (resolved).

Referral: 53 yrs old man is c/o Dizziness x 2 yrs.

Martha assisted in translation.

Pt reports he has pain in the skin of his R-post head for 3 months, not 2 years. No neck pain or in his back. Pt feels the pain is inside his head, but pt also indicates when he presses on the skin of his head, it elicits pain. Pt reports the symtoms began when he was in UOF 3 month ago, in May 25, 2016; he was kicked in his head and in his left stomach. He felt a bit dizzy for about 2 days, but no LOC, no AMS. Pt reports there was no scalp or any other bleeding then. When questioned about the small scar at the R-occipital location, pt reports "someone threw stone at his head and he required stitches then" at age 10 yrs old, but no subsequent problems. Pt reports he was told by others there was black and blue along his post right neck. When asked about the skin pucker on his R-post neck pt states it appeared AFTEr the UOF, but does not cause him any pain or any discomfort. The pain is mild, intermittent, and mostly in the R-post boney occiput. Pt expected the pain to resolve by now. No pain anywhere else in his head or face or neck. No focal weakness or numbness in b/l UE and LE, but reports a little discomfort on ROM of his Left shoulder that is improved with rotations of his left shoulder joint. No B/B issues, no incontinence.

When questioned about any dizziness/ vertigo/ mareo, pt responds "not anymore", none now. Pt reports he initially felt a bit dizzy and had difficulty getting up that later resolved or may occur still very mildly and occasionaly. No vertigo ever at any point. He reports after the trauma, when he woke up in the morning, he needs to take his time standing up; otherwise, he felt "dizzy", lightheaded. He reports those sypmtoms have imrpoved gradually adn were gone after 1 month.

Pt reprots he felt a bit disoriented and had difficulty remembering his phone number and returned to baseline after 1 week. Pt reports some difficulty sleeping since admission to jail but no changes since the

trauma. Pt denies any visual changes, no blurry or double vision.

Pt denies any problems with his ears. When questioned further, pt reports he was told he could not hear well out of his left ear only, but was given drops last Friday and his hearing went back to normal. No tinnitus. When questioned about the cotton ball in his Right ear canal, pt states he is not aware of it. Pt admits to using a lot of Qtips. Pt again denies any dizziness for 2 years. Pt admits to good exercise tolerance and reports he feels occasional "pause" when he does push ups.

Very vague history despite extensive attempts to clarify with the translator. Pt seems to indicate htat his mareo/ lightheadedness has mostly resolved, his left hearing deficit resolved. He still continues to have occasional R-occipital pain that is ONLY present when he touches/ presses on his scalp, that he tried taking Motrin for from another inmate with some relief but only had 3 doses.

Extensive chart review was performed and was discussed with the pt.

Dr. Kramer ENT 8/ 10/ 16: SPC-ENT Patient presents with intermintent left hearing loss, no evident tinnitus or Vertigo.

HEENT: Otoscopic exam. revels bilateral obstructing Cerumen. TM's are not visualized.

1. Impacted cerumen Start Debrox Solution, 6.5 %, Total Dose: 10cc, Otic, Every 12 Hours, 10 days, 1box, Refills 1, Drug Source: Pharmacy Follow Up 1Week (Reason: Aural Irrigation.)

Cardiology Dr. Lorin 8/ 8/ 16: Cardiology Ricardo, leon 53 yo with dizziness for 2 years. Used spanish interpreter.

ECG 6/ 9/ 16 sinus, nl ecg. No evidence of preexcitation. Pt has never been diagnosed with any heart disease. Last year he saw a cardiologist for occasional palpitations. Last palpitations were 5months ago. Only testing was ECG.

-htn, -dm, -cigs.

Good exercise tolerance - does one hour of exercise -runs, pushups each day. No chest pain. Denies syncope.

HEART: regular rate and rhythm, normal S1S2, no murmur, no rub, no gallop, or click.

Pt currently asymptomatic for past 5 months. Excellent exercise duration.

1. Dizziness and giddiness Notes: If palpitations recur, can consider starting metoprolol.

LABS: Utox/ RPR/ HepA/ CBC=wnl, Chem with gluc=140.

Examination

General Examination:

GENERAL APPEARANCE: well-developed, no acute distress.

NECK: GENERAL:-, supple, no carotid bruit.

HEART: HEART SOUNDS:-, normal S1S2.

Neurological:

CORTICAL FUNCTIONS: alert and oriented X 3, comprehension and language intact, general knowledge and judgement within normal variation.

CRANIAL NERVES: CN II - Visual acuity , grossly normal , CN - II Visual Fields: , normal to confrontation testing , CN - III Pupils: , equal , round , reactive to light and accomodation , CN III, IV and VI - EOM:, normal extraocular movements and alignment to gaze , CN V -

Trigeminal:, normal facial sensation and ability to clench jaw , CN VII - Facial: , symmetric movement of the forehead and mouth with tight closure of the eyes , CN VIII - Auditory: , hearing was normal , CN IX - Glossophar: , uvula rises normally with gag and phonation, CN XI - Spinal access: , able to raise shoulders and turn head to midline against resistance , CN XII - Hypoglossal:, tongue protrudes in midline and no tremor or fasciculations. No papilledema b/l. Otoscopic exam: R-ear pt has inserted cotton, L-ear obscured by wax. No facial/ ant cervical TTP. No frontal/ temp TTP. Pt has a small 2 cm well -healed scar on R-occipital region that he reports is tender with superficial radiating pain down the R-occiput and ending at a skin puckering on R-post neck behind the posterior margin of R-SCM. No SCM TTP b/l. Neck with full ROM. No mastoid TTP. .

MOTOR STRENGTH: V/ V bilaterally in UE and LE, normal tone, no facics, no atrophy..

SENSORY: normal, pinprick sensation intact, vibration sensation intact, pain adn temp sensation normal , no spinal TTP. .

REFLEXES: bilaterally symmetrical at 1+ in b/l B, T, BR and in b/l P and A, babinski negative.

TREMORS: absent.

COORDINATION: finger to nose normal bilaterally .

GAIT AND STATION: Within normal limits, Romberg was negative.

SPEECH: normal.

MUSCLE BULK: normal .

PRONATOR DRIFT: not present .

Assessments

1. Dizziness and giddiness - 780.4

Treatment

1. Dizziness and giddiness

Start Ibuprofen Tablet, 400 MG, Total Dose: 400mg, Orally, Every 6 Hours, as needed, 7 days, Drug Source: Pharmacy

Notes: 53yo RH Spanish-speaking HM with PMHx R-occipital trauma May 2016 with subsequent Left decreased hearing and lightheadedness, R-occipital pain, presented on 8/ 16/ 16 for initial evaluation of lightheadedness (resolved).

Exam with No papilledema b/l and no CN abnormalities. Otoscopic exam: R-ear pt has inserted cotton, L-ear obscured by wax. No facial/ ant cervical TTP. No frontal/ temp TTP.

Pt has a small 2 cm well -healed scar on R-occipital region that he reports is tender with superficial radiating pain down the R-occiput and ending at a skin puckering on R-post neck behind the posterior margin of R-SCM. No SCM TTP b/l. Neck with full ROM.

IMP: very vague history, symptoms appear to have mostly resolved, though subjective complaints fluctuate, r/ o intracranial/ skull fracture (unlikely), scalp, subQ, focal MSK spasm, focal neuralgia (less likely).

PLAN:

-Head CT no contrast to rule out intracranial abnormality, bleed, skull;

-continue f/ u with ENT, need to remove R-ear canal cotton balls and evaluate TM, as well as right post neck; continue drop for now;

-HA diary;

-Motrin prn;

-further eval based on the resutls of the above.

Follow Up
4-6 Weeks

Disposition: General Population

Appointment Provider: Olga Segal, MD

☒

Electronically signed by Olga Segal MD, MD on 08/16/2016 at 01:32 PM EDT

Sign off status: Completed

Addendum:
08/18/2016 04:49 PM Walker, Curt > Pt was seen. Medication written by consultant. Pt to RTC 4 - 6 WEEKS

West Facility
16-06 Hazen Street
East Elmhurst, NY 11370
Tel: 347-774-7000
Fax: 347-774-8088

NYC HEALTH + HOSPITALS

Insurance: Self Pay

RICARDO, LEON JESUS

NYSID: 15499554N BookCase: 3491606748
Facility Code: RNBC Housing Area: 4UN
53 Y old Male. DOB: 10/15/1962
Account Number: 330345
xxx E 182 ST, BRONX, NY

Appointment Facility: West Facility

08/16/2016

Appointment Provider: Olga Segal, MD

Current Medications

Taking

- Debrox 6.5 % Solution Total Dose: 10cc Every 12 Hours, stop date 08/30/2016, Drug Source: Pharmacy

Allergies

N.K.D.A.

Reason for Appointment

1. Neuro

History of Present Illness

Notes::

53yo RH Spanish-speaking HM with PMHx R-occipital trauma May 2016 with subsequent Left decreased hearing and lightheadedness, R-occipital pain, presented on 8/16/16 for initial evaluation of lightheadedness (resolved).

Referral: 53 yrs old man is c/o Dizziness x 2 yrs .

Martha assisted in translation.

Pt reports he has pain in the skin of his R-post head for 3 months, not 2 years. No neck pain or in his back. Pt feels the pain is inside his head, but pt also indicates when he presses on the skin of his head, it elicits pain. Pt reports the symtoms began when he was in UOF 3 month ago, in May 25, 2016; he was kicked in his head and in his left stomach. He felt a bit dizzy for about 2 days, but no LOC, no AMS. Pt reports there was no scalp or any other bleeding then. When questioned about the small scar at the R-occipital location, pt reports "someone threw stone at his head and he required stitches then" at age 10 yrs old, but no subsequent problems. Pt reports he was told by others there was black and blue along his post right neck. When asked about the skin pucker on his R-post neck pt states it appeared AFTEr the UOF, but does not cause him any pain or any discomfort. The pain is mild, intermittent, and mostly in the R-post boney occiput. Pt expected the pain to resolve by now. No pain anywhere else in his head or face or neck. No focal weakness or numbness in b/l UE and LE, but reports a little discomfort on ROM of his Left shoulder that is improved with rotations of his left shoulder joint. No B/B issues, no incontinence.

When questioned about any dizziness/vertigo/mareo, pt responds "not anymore", none now. Pt reports he initially felt a bit dizzy and had difficulty getting up that later resolved or may occur still very mildly and occasionaly. No vertigo ever at any point. He reports after the trauma, when he woke up in the morning, he needs to take his time standing up; otherwise, he felt "dizzy", lightheaded. He reports those sypmtoms have imrpoved gradually adn were gone after 1 month.

Pt reprots he felt a bit disoriented and had difficulty remembering his phone number and returned to baseline after 1 week. Pt reports some difficulty sleeping since admission to jail but no changes since the

Trigeminal:, normal facial sensation and ability to clench jaw , CN VII - Facial: . symmetric movement of the forehead and mouth with tight closure of the eyes , CN VIII - Auditory: , hearing was normal , CN IX - Glossophar: , uvula rises normally with gag and phonation. CN XI - Spinal access: , able to raise shoulders and turn head to midline against resistance . CN XII - Hypoglossal:, tongue protrudes in midline and no tremor or fasciculations. No papilledema b/l. Otoscopic exam: R-ear pt has inserted cotton, L-ear obscured by wax. No facial/ant cervical TTP. No frontal/temp TTP. Pt has a small 2 cm well -healed scar on R-occipital region that he reports is tender with superficial radiating pain down the R-occiput and ending at a skin puckering on R-post neck behind the posterior margin of R-SCM. No SCM TTP b/l. Neck with full ROM. No mastoid TTP. .

MOTOR STRENGTH: V/ V bilaterally in UE and LE, normal tone, no facics, no atrophy..

SENSORY: normal, pinprick sensation intact, vibration sensation intact, pain adn temp sensation normal , no spinal TTP. .

REFLEXES: bilaterally symmetrical at 1+ in b/l B, T, BR and in b/l P and A, babinski negative.

TREMORS: absent.

COORDINATION: finger to nose normal bilaterally .

GAIT AND STATION: Within normal limits, Romberg was negative.

SPEECH: normal.

MUSCLE BULK: normal .

PRONATOR DRIFT: not present .

Assessments

1. Dizziness and giddiness - 780.4

Treatment

1. Dizziness and giddiness

Start Ibuprofen Tablet, 400 MG, Total Dose: 400mg, Orally, Every 6 Hours, as needed, 7 days, Drug Source: Pharmacy

Notes: 53yo RH Spanish-speaking HM with PMHx R-occipital trauma May 2016 with subsequent Left decreased hearing and lightheadedness, R-occipital pain, presented on 8/16/16 for initial evaluation of lightheadedness (resolved).

Exam with No papilledema b/l and no CN abnormalities. Otoscopic exam: R-ear pt has inserted cotton, L-ear obscured by wax. No facial/ant cervical TTP. No frontal/temp TTP.

Pt has a small 2 cm well -healed scar on R-occipital region that he reports is tender with superficial radiating pain down the R-occiput and ending at a skin puckering on R-post neck behind the posterior margin of R-SCM. No SCM TTP b/l. Neck with full ROM.

IMP: very vague history, symptoms appear to have mostly resolved, though subjective complaints fluctuate. r/o intracranial/skull fracture (unlikely), scalp, subQ, focal MSK spasm, focal neuralgia (less likely).

PLAN:

-Head CT no contrast to rule out intracranial abnormality, bleed, skull;

-continue f/u with ENT. need to remove R-ear canal cotton balls and evaluate TM, as well as right post neck; continue drop for now;

-HA diary;

-Motrin prn;

NYC HEALTH+ HOSPITALS

Insurance: Self Pay

RICARDO, LEON JESUS

NYSID: 13499354N BookCase: 3491606178
Facility Code: RNDC Housing Area: 4CS
54 Y old Male, DOB: 10/15/1962
Account Number: 330345
312 E 183 ST, BRONX, NY

Appointment Facility: West Facility

11/01/2016

Sai Kolla, MD

Reason for Appointment
1. specialty clinic NEURO

History of Present Illness
Notes::
53 yrs old rt handed male with hx of head injury about five months ago resulting dizziness and sub occipital pain came for f/u. Pt reports that he is feeling much better than before regarding dizziness but has rt sided neck pain. Denies h/v, n/v, imbalance, visual problems and weakness in the extremities or b/b disturbances. Pt did not go for Ct scan of head to BVH. Pt was seen by ENT for decreased hearing.

Examination
General Examination:
GENERAL APPEARANCE: well-appearing, no acute distress.
Neurological:
CORTICAL FUNCTIONS: alert and oriented X 3, speech fluent.
CRANIAL NERVES: III , IV, VI - EOM were full with normal pursuit and saccade, No ptosis or nystagmus, V - Motor V intact, Pinprick, light touch intact in all three divisons, VII - No asymmetry or weakness, VIII - Actuity intact to finger rub normal in rt ear and decreased in left ear, IX , X- Palate rose in midile., XI - Sternocleidomastoid, trapezius strength intact., XII - Tongue protruded midline w/o atrophy or fasciculations.
MOTOR STRENGTH: V/V bilaterally, no drift, no cogwheeling. Mild tederness presont over rt side of the head in sub occipital area. No tederness over cervical paraspinals and movements of the neck not restricted..
SENSORY: normal bilaterally for L/T.
REFLEXES: bilaterally symmetrical, .
PLANTARS: downgoing bilaterally, Hoffman sign neg.
CEREBELLAR SIGNS: absent.
TREMORS: absent.
COORDINATION: finger-to-nose and rapid alternating movements were intact, No ataxia.
GAIT AND STATION: Within normal limits, Romberg was negative.

Assessments
1. Head injury, unspecified - 959.01

NYC HEALTH+ HOSPITALS

RICARDO, LEON JESUS

NYSID: 13499354N BookCase: 3491606178
Facility Code: RNDC Housing Area: 4CS
54 Y old Male, DOB: 10/15/1962
Account Number: 330345
312 E 183 ST, BRONX, NY

Insurance: Self Pay

Appointment Facility: Robert N. Davoren Center

11/16/2016

Appointment Provider: Donald Mcgibbon, PA

Past Medical History
No Medical History.

Allergies
N.K.D.A.

Reason for Appointment
1. C/o headache

History of Present Illness
VISIT COMPLEXITY SCALE:
NON-INTAKE ACUITY
Non-Intake Acuity Scale 2: *Complicated sick call (problem requiring diagnostic evaluation, documented history, physical exam, specified follow up) OR One chronic condition addressed with components specified in (3)*
C/O headache. S/P head injury approx. 5 monyths ago. State had daily headaches that is approx5-7 on pain scale. State today feels like 7. patient seen by Neuro. 11/1/2016 with CT scan ordered/pending. Denies new symptoms,nausea,dizziness of chest pain.

Vital Signs

BP		
115/68	11/16/2016 07:49:09 PM	Donald Mcgibbon
Pulse		
66	11/16/2016 07:49:09 PM	Donald Mcgibbon
RR		
16	11/16/2016 07:49:09 PM	Donald Mcgibbon
Temp		
97.2	11/16/2016 07:49:09 PM	Donald Mcgibbon
Pain scale		
7	11/16/2016 07:49:09 PM	Donald Mcgibbon

Examination

General Examination:
GENERAL APPEARANCE: well-developed, no acute distress.
HEENT: HEAD:-, normocephalic, EYES:-, PERRLA, EOMI.
NECK: GENERAL:-, supple, no nuchal rigidity.

HEART: PMI:-, normal, RATE:-, regular, RHYTHM:-, regular.
LUNGS: clear to auscultation.
NEUROLOGIC EXAM: alert and oriented x 3, CN's II-XII grossly intact.

Assessments

1. Head injury, unspecified - 959.01

Treatment

1. Head injury, unspecified

Start Naprosyn Tablet, 250 MG, Total Dose: 500 mg po stat then 500 mg, Orally, Twice a Day, as needed, 4 days, Drug Source: Pharmacy

Appointment Provider: Donald Mcgibbon, PA

Electronically signed by Donald Mcgibbon PA on 11/16/2016 at 11:05 PM EST

Sign off status: Completed

Robert N. Davoren Center
11-11 Hazen Street
East Elmhurst, NY 11370
Tel: 347-774-7000
Fax: 347-774-8088

NYSID: 13499354N **BookCase:** 3491606178
Facility Code: RNDC **Housing Area:** 4CS
Patient: RICARDO, LEON JESUS
Account Number: 330345
DOB: 10/15/1962 **Age:** 54 Y **Sex:** Male
Phone:
Address: 312 E 183 ST, BRONX, NY

Provider: Todd Cowdery, MD
Date: 11/29/2016

Subjective:

Chief Complaints:

1. Recurrent headache, hearing loss.

HPI:

VISIT COMPLEXITY SCALE:

NON-INTAKE ACUITY

Non-Intake Acuity Scale *3: Two Chronic Conditions addressed including narrative assessment and plan for each, f/u time frame specified, appropriate labs and referrals*

TEMPLATES:

Sick Call: (patient Spanish speaking, communication via phone translator service, Mark, #247892)
Patient questions status of Head CT recommended by Neurology to f/u recurrent R occipital headaches, L partial hearing loss, lightheaded spells which he relates have occurred s/p 5/16 R occipital head trauma. Notes no worsening of symptoms. Questions why hearing has not been checked.

Review of chart:

- Neurology evaluations 8/16, 9/7, 11/1 2016
- ENT evaluation 8/17/16: cerumen impaction, resolved post irrigation.

Medications: Flomax 0.4 MG Capsule Total Dose: 0.4 Daily, stop date 02/19/2017, KOP: No, Drug Source: Pharmacy

Allergies: N.K.D.A.

Objective:

Vitals:

BP		
111/67	11/29/2016 03:03:31 PM	Todd Cowdery
Pulse		
61	11/29/2016 03:03:31 PM	Todd Cowdery
RR		
16	11/29/2016 03:03:31 PM	Todd Cowdery
Temp		
96.3	11/29/2016 03:03:31 PM	Todd Cowdery

Examination:

General Examination:

GENERAL APPEARANCE: well-appearing, no acute distress.
HEENT: **HEAD:-**, normocephalic, atraumatic, **EYES:-**, PERRLA, EOMI, **FUNDI:-**, normal, **EARS:-**, external ear unremarkable, partial cerumen impaction, able to hear clicked fingernails bilaterally **NOSE:-**, normal pink mucosa, **THROAT:-**, clear, no exudate.
ORAL CAVITY: mucosa moist.
NECK: no lymphadenopathy, no thyromegaly, nontender and FROM, supple.
HEART: RATE:-, regular, RHYTHM:-, regular, HEART SOUNDS:-, normal S1S2, MURMURS:-, none.
CHEST: SHAPE AND EXPANSION:-, normal.
LUNGS: clear to auscultation, no wheezes/rhonchi/rales.
SKIN: well healed R occipital area scar, ~1cm; R posterior lateral neck: ~1-2cm indented area, nontender, no signs infection.
NEUROLOGIC EXAM: CN's II-XII grossly intact.
MENTAL STATUS: alert , oriented to person, oriented to place, oriented to time, normal speech,

euthymic mood, No homicidal thinking, No suicidal thinking, no hallucinations, no delusions.

Assessment:

Assessment:
1. Headache - 784.0
2. Head injury, unspecified - 959.01
3. CONDUCT HEARING LOSS NOS - 389.00

Plan:

1. Headache
Notes: 1. Discussed w/ patient Head CT scheduling pending:
"Shaaban,Morsi , MD 11/7/2016 4:08:48 PM > seen by Neurologist on island , request CT of the head without contrast
Smith,Carol 11/15/2016 11:56:17 AM > Reviewed by Patient Services for Processing
Smith,Carol 11/18/2016 9:53:12 AM > As per Grace B/BHC to J Marshall/BHC scheduling unit, please open a RP visit. Re-entering referral for appointment"
2. Email sent to SMD re: status update re: scheduling
3. f/u w/ Neurology as scheduled.

2. CONDUCT HEARING LOSS NOS

Referral To: Audiologist (REF) Bellevue Audiologist (Pending Approval)
Reason: c/o decreased hearing L ear s/p head trauma 6 mos ago

Disposition:
Disposition: Return to Current Housing

Provider: Todd Cowdery, MD
Patient: RICARDO, LEON JESUS **DOB:** 10/15/1962 **Date:** 11/29/2016

Electronically signed by Todd Cowdery , MD on 11/ 29/ 2016 at 03:51 PM EST
Sign off status: Completed

RNDC

BELLEVUE HOSPITAL CENTER
DEPARTMENT OF RADIOLOGY
DOWNTIME PAPER REQUEST FOR RADIOLOGY EXAMS
C.A.T SCAN (Tel: 212.562.3854)

DATE OF REQUEST: 3/16/16

REQUESTED BY: Zega

CONTACT NUMBER: 718 546 5200

PATIENT NAME: Ricardo, Leon Jesus

MRN: 3491606178

DOB: 10/15/62

SEX: M

REFERRING CLINICIAN: Correctional Health system

☐ BRAIN ☐ PITUITARY	☐ PARANASAL SINUS ☐ FACIAL ☐ ORBIT ☐ MANDIBLE ☐ NECK ☐ TEMPORAL BONE ☐ BRACHIAL PLEXUS ☐ OTHER - SPECIFY:	☐ CHEST SPECIFY: ☐ ABDOMEN / PELVIS SPECIFY:	☐ UPPER EXTREMITY SPECIFY: ☐ LOWER EXTREMITY SPECIFY: ☐ PELVIS / ACETABULUM ☐ LEFT ☐ RIGHT	☐ SPECIAL PROCEDURE SPECIFY:
SPINE: ☐ CERVICAL ☐ THORACIC ☐ LUMBAR				

☐ NON CONTRAST ☐ IV CONTRAST ☐ ORAL CONTRAST ☐ REDICAT ☐ GASTROGRAFIN

☐ SITE OF SUSPECTED LESION

☐ CLINICAL DIAGNOSIS

PERTINENT HISTORY: R Occipital Headache

RESULTS OF OTHER RELATED STUDIES: pain

PRIOR CT: YES ___ NO ___ IF YES YEAR: _____ INSTITUTION:

CONTRAST SURVEY:

IS THE PATIENT DIABETIC: ☐ YES ☐ NO

BUN / CREATININE : _____ / _____ (must be within the last SIX MONTHS)

ANY HISTORY OF ASTHMA: ☐ YES ☐ NO

ALLERGIES: ☐ YES ☐ NO

IF YES, SEE STEROID PREP PRIOR TO EXAMINATION →

****STEROID PREP:****

PREDNISONE 50 mg PO 24 / 12 / & 1HR

MEDICATION GIVEN ___YES ___NO

IS THE PATIENT PREGNANT: ☐ YES ☐ NO

INFECTIOUS DISEASE PRECAUTIONS (IF YES, BE SPECIFIC): ☐ YES ☐ NO _____

DNR STATUS: ___ RESUSCITATE ___ DNR (TO BE CONFIRM IN CHART AT BELLEVUE RADIOLOGY)

BELOW THIS LINE FOR CT RADIOLOGY USE ONLY

CT PROTOCOL:

RADIOLOGIST APPROVAL

DATE SCHEDULED	RUN NUMBER	DATE COMPLETED	DISK

TECH COMMENTS:

3491606178

10/15/62

BELLEVUE HOSPITAL CENTER
DEPARTMENT OF RADIOLOGY
DOWNTIME PAPER REQUEST FOR RADIOLOGY EXAMS
C.A.T SCAN (Tel: 212.562.3054)

DATE OF REQUEST: 9/2/16	PATIENT NAME: RICARDO, Leon Jesus
REQUESTED BY: Sam JOSE	MRN:
CONTACT NUMBER: 718 546 5200	DOB: 10/15/62
REFERRING CLINIC/UNIT: Correctional Health system	SEX: M

☑ BRAIN ☐ PITUITARY	☐ PARANASAL SINUS ☐ FACIAL ☐ ORBIT ☐ MANDIBLE ☐ NECK ☐ TEMPORAL BONE ☐ BRACHIAL PLEXUS ☐ OTHER - SPECIFY:	☐ CHEST SPECIFY:	☐ UPPER EXTREMITY SPECIFY: ☐ LOWER EXTREMITY SPECIFY:	☐ SPECIAL PROCEDURE SPECIFY:
SPINE: ☐ CERVICAL ☐ THORACIC ☐ LUMBAR		☐ ABDOMEN / PELVIS SPECIFY:	☐ PELVIS / ACETABULUM ☐ LEFT ☐ RIGHT	

☑ NON CONTRAST ☐ IV CONTRAST ☐ ORAL CONTRAST ☐ REDICAT ☐ GASTROGRAFIN

☐ SITE OF SUSPECTED LESSION
Head

☒ CLINICAL DIAGNOSIS
DIZZINESS / FAINTNESS

PERTINENT HISTORY
Seen by WF neurology
10 R10" Intracranial abnormal, bleed, skull Fx

RESULTS OF OTHER RELATED STUDIES

PRIOR CT: YES ___ NO ☑ IF YES YEAR: ___ INSTITUTION:

CONTRAST SURVEY:
IS THE PATIENT DIABETIC: ☐ YES ☑ NO
BUN / CREATININE: ___/___ (must be within the last SIX MONTHS)

ANY HISTORY OF ASTHMA: ☐ YES ☑ NO
ALLERGIES: ☐ YES ☑ NO
IF YES, SEE STEROID PREP PRIOR TO EXAMINATION

****STEROID PREP:****
PREDNISONE 50 mg PO 24 / 12 / & 1HR
MEDICATION GIVEN ___YES ___NO

IS THE PATIENT PREGNANT: ☐ YES ☑ NO
INFECTIOUS DISEASE PRECAUTIONS (IF YES, BE SPECIFIC): ☐ YES ☐ NO ___
DNR STATUS: ___ RESUSCITATE ___ DNR (TO BE CONFIRM IN CHART AT BELLEVUE RADIOLOGY)

BELOW THIS LINE FOR CT RADIOLOGY USE ONLY

CT PROTOCOL: RADIOLOGIST APPROVAL

DATE SCHEDULED	RUN NUMBER	DATE COMPLETED	DISK

TECH COMMENTS:

NYC HEALTH+ HOSPITALS

PATIENT REFUSAL OF TREATMENT

PATIENT'S LAST NAME	FIRST NAME		NYSID NUMBER	
RICARDO	LEON JESUS		13499354N	
BOOK AND CASE NUMBER	**DATE**	**TIME**	**FACILITY**	**DATE OF ADMISSION**
3491606178	07/20/2016	07:14:05 PM	Robert N. Davoren Center (.	05/27/2016 02

This is to certify that I am over the age of eighteen (18) years of age and I am refusing the following:

- ☐ MEDICAL EVALUATION [HISTORY AND PHYSICAL]
- ☐ MEDICAL SERVICES
- ☐ ADMINISTRATION OF MEDICATION (OTHER THAN PSYCHIATRIC)
- ☐ LABORATORY SERVICES ☐ X-RAY SERVICES
- ☐ HEAT SENSITIVE HOUSING
- ☐ OTHER (SPECIFY): Medical Flu (Dizziness; Pain Labs)
- ☐ MENTAL HEALTH EVALUATION
- ☐ MENTAL HEALTH SERVICES
- ☐ ADMINISTRATION OF PSYCHIATRIC MEDICATION
- ☐ DIAGNOSTIC TESTING
- ☐ CLINICAL APPOINTMENT AT:

I understand this refusal is against the advice of my health care practitioner. I acknowledge that I have been informed of the risks, consequences and the danger to my health and possibly to my life which may result from my refusal of this procedure/treatment. I have been given time to ask questions about my condition and about my decision to refuse the procedure/treatment which my health care provider has explained to me is medically indicated and necessary.

I voluntarily assume the risks and accept the consequences of my refusal of the procedure/treatment and I am releasing all of the health care providers, the facility and its staff from any and all liability for ill effects that may result from my refusal of treatment.

X Jesus Ricardo — 07/20/2016

Signature of Patient — **Date**

(VIA interpreter) with patient Consent.

☐ Patient refused to present to clinic for informed consent discussion (Refused to Refuse)

07/20/2016

Signature of Person Documenting Patient's Refusal to Refuse — **Date**

The above named patient refused the procedure/treatment, which is medically indicated, and necessary. I explained to the patient, the risks, consequences and dangers of refusing the procedure/treatment include but are not limited to the following:

Poor Management of medical Problems; Complications; Death

I provided the above named patient with the opportunity to ask questions, I have answered the questions asked and it is my professional opinion that the patient understands what I have explained.

D - Abiri MD — 07/20/2016

	PM	
Temp		
98	08/19/2016 05:10:09 PM	Jane Sanjose
SaO2		
98	08/19/2016 05:10:09 PM	Jane Sanjose
Glucose		
104	08/19/2016 05:10:09 PM	Jane Sanjose

Examination

General Examination:

GENERAL APPEARANCE: no acute distress.
HEENT: normocephalic.
NECK: supple.
HEART: bradycardic.
CHEST: normal.
LUNGS: normal.
ABDOMEN: normal.
EXTREMITIES: normal ROM.
BACK: unremarkable.
MUSCULOSKELETAL: shoulders full range of motion.
NEUROLOGIC EXAM: alert and oriented x 3.
MENTAL STATUS: alert .

Assessments

1. ROUTINE MEDICAL EXAM - V70.0
2. Dizziness and giddiness - 780.4, SUGGEST CT NON CONTRAST, EMERGENCY PICK UP FOR DIZZINESS/ SEEN BY NEUROLOGY 8/18/16
3. Unspecified peripheral vertigo - 386.10
4. EXCESSIVE HEAT: WEATHER - E900.0
5. REFUSED HEAT SENSITIVE - RI201
6. Head injury, unspecified - 959.01, CLAIS 4/2016

Treatment

1. ROUTINE MEDICAL EXAM

IMAGING: EKG (DI)

2. Dizziness and giddiness

Start Meclizine HCl Tablet, 25 MG, Total Dose: 1TAB, Orally, BID,PRN/ GIVE STAT DOSE, 4 days, Drug Source: Pharmacy
Referral To:Radiology (REF) Bellevue Radiology
Reason:seen by rikers neurology/ request ct head

3. Unspecified peripheral vertigo

LAB: HEMOGLOBIN A1C (glycohemoglobin)
LAB: THYROID STIMULATING HORMONE
LAB: HEPATIC FUNCTION

NYC HEALTH+ HOSPITALS

RICARDO, LEON JESUS

NYSID: 13499354N BookCase: 3491606178
Facility Code: RNDC Housing Area: 4UN
53 Y old Male, DOB: 10/15/1962
Account Number: 330345
312 E 183 ST, BRONX, NY

Insurance: Self Pay
Appointment Facility: Robert N. Davoren Center (Adolescents)

06/09/2016

Appointment Provider: Jane Sanjose, MD

Allergies
N.K.D.A.

Reason for Appointment
1. OPERATION CALLED TO SEE PT
2. pt seen/ examined w/ chaperon nurse RILLERA
3. PT CLAIMS HE FELT SOMETHING LIKE A BALL IN BOTH THIGH ABOUT 1 YEAR AGO.PT ALSO CLAIMS THAT HE HAD PALPITATION ABOUT 3 MONTHS AGO.
4. PT DENIES ANY CHEST PAIN TODAY,DENIES HEADACHE,DENIES SHORTNESS OF BREATH,DENIES ANY TRAUMA TODAY.

History of Present Illness
VISIT COMPLEXITY SCALE:
NON-INTAKE ACUITY
Non-Intake Acuity Scale 2: *Complicated sick call (problem requiring diagnostic evaluation, documented history, physical exam, specified follow up) OR One chronic condition addressed with components specified in (3)*

Vital Signs

BP		
125/75	06/09/2016 08:49:04 PM	Jane Sanjose
Pulse		
75	06/09/2016 08:49:04 PM	Jane Sanjose
RR		
16	06/09/2016 08:49:04 PM	Jane Sanjose
Temp		
98	06/09/2016 08:49:04 PM	Jane Sanjose
SaO2		
99	06/09/2016 08:49:04 PM	Jane Sanjose

Examination

General Examination:

NYSID: 13499354N **BookCase:** 3491606178

RICARDO, LEON JESUS

312 E 183 ST, BRONX, NY

DOB: 10/15/1962 **Age:** 54 Y **Sex:** male

Home:
Work:
Cell:
Email:
Advance Directive:

Primary Insurance:
PCP:
Account Number: 330345

Allergies : N.K.D.A

Medical History

Active Problem List

Code	Name	Specify	Notes	Added On	Modified On	Modified By
278.00	OBESITY NOS			05/28/2016	05/28/2016	Ihenacho, Gloria
785.1	Palpitations			06/09/2016	06/09/2016	Sanjose, Jane
V70.0	ROUTINE MEDICAL EXAM			06/09/2016	08/19/2016	Sanjose, Jane
782.2	Localized superficial swelling, mass, or lump			06/09/2016	06/09/2016	Sanjose, Jane
389.00	CONDUCT HEARING LOSS NOS			07/14/2016	07/14/2016	Kumar, Asha
784.0	Headache	nad		08/05/2016	08/05/2016	Criss-Horlback, Sheila
380.4	Impacted cerumen			08/10/2016	08/17/2016	Kramer, Theodore
386.10	Unspecified peripheral vertigo			08/19/2016	08/19/2016	Sanjose, Jane
E900.0	EXCESSIVE HEAT: WEATHER			08/19/2016	08/19/2016	Sanjose, Jane
RI201	REFUSED HEAT SENSITIVE			08/19/2016	08/19/2016	Sanjose, Jane
959.01	Head injury, unspecified	CLAIS 4/2016		08/19/2016	08/19/2016	Sanjose, Jane
780.4	Vertigo NOS			08/30/2016	08/30/2016	Nwogwugwu, Chika
790.21	Impaired fasting glucose			09/29/2016	09/29/2016	Liburd, Jessy
278.02	Overweight			09/29/2016	09/29/2016	Liburd, Jessy
753.9	URINARY ANOMALY NOS			11/21/2016	11/21/2016	Liburd, Jessy
600.00	BPH W/O URINARY OBSTRUCT			11/21/2016	11/21/2016	Liburd, Jessy

Medications

Name strength formulation, Sig: take route frequency

Flomax 0.4 MG Capsule, Total Dose: 0.4 Orally Daily Start Date: 11/21/2016 KOP: No DrugSource: Pharmacy

Naproxen 250 MG Tablet, Total Dose: 500 mg Orally Twice a Day Start Date: 12/13/2016 KOP: DrugSource: Pharmacy

GENERAL APPEARANCE: no acute distress/ pt examined w/ NURSE RILLERA.
HEENT: normocephalic.
NECK: supple.
HEART: normal.
LUNGS: normal.
ABDOMEN: normal without tenderness, masses, or megaly, soft, BS present,obese.
SKIN: MASS,ABOUT 1CM ,NON TENDER,NO BLEEDING LEFT THIGH.
EXTREMITIES: normal ROM, no cyanosis, no clubbing.
BACK: unremarkable.
MUSCULOSKELETAL: shoulders full range of motion.
NEUROLOGIC EXAM: alert and oriented x 3.
MENTAL STATUS: alert .

Assessments
1. Palpitations - 785.1 (Primary)
2. ROUTINE MEDICAL EXAM - V70.0
3. Localized superficial swelling, mass, or lump - 782.2

Treatment
1. ROUTINE MEDICAL EXAM
IMAGING: EKG (DI)

2. Localized superficial swelling, mass, or lump
Referral To: Surgery WF Surgery
Reason: PT CLAIMS FELT SOMETHING LIKE A BALL IN BOTH THIGHS X 1 YEAR AGO,,R/ O LIPOMA OR CYST;;CLAIMS GOT WORST A MONTH AGO.

Disposition: General Population

Appointment Provider: Jane Sanjose, MD

☒

Electronically signed by Jane Sanjose MD on 06/09/2016 at 11:40 PM EDT

Sign off status: Completed

NYC HEALTH+ HOSPITALS

RICARDO, LEON JESUS

NYSID: 13499354N BookCase: 3491606178
Facility Code: RNDC Housing Area: 4UN
53 Y old Male, DOB: 10/15/1962
Account Number: 330345
312 E 183 ST, BRONX, NY

Insurance: Self Pay

Appointment Facility: West Facility

09/07/2016

Sai Kollas, MD

Reason for Appointment
1. patient seen 8/16/16;4-6 Weeks

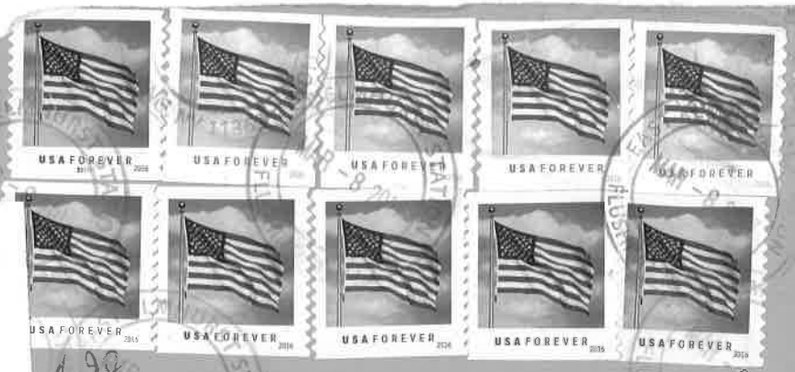
History of Present Illness
Notes::
53 yrs old male with hx of dizziness was seen by Dr. segal came for f/u. pt states that he is feeling much better, dizziness is mild now. ear wax was removed. Denies headaches, n/v, imbalance, visual disturbances and weakness in the extremities. pt went for ct of head and result is not available at this time.

Examination
General Examination:
GENERAL APPEARANCE: well-appearing, no acute distress.
Neurological:
CORTICAL FUNCTIONS: alert and oriented X 3.
CRANIAL NERVES: , III , IV, VI - EOM were full with normal pursuit and saccade, No ptosis or nystagmus, V - Motor V intact, Pinprick, light touch intact in all three divisons, VII - No asymmetry or weakness, VIII - Actuity intact to finger rub bilaterally, IX , X- Palate rose in midile., XI - Sternocleidomastoid, trapezius strength intact., XII - Tongue protruded midline w/o atrophy or fasciculations.
MOTOR STRENGTH: V/V bilaterally, no drift, no cogwheeling.
SENSORY: normal bilaterally for L/T.
REFLEXES: bilaterally symmetrical.
CEREBELLAR SIGNS: absent.
TREMORS: absent.
COORDINATION: finger-to-nose and rapid alternating movements were intact, No ataxia.
GAIT AND STATION: Within normal limits, Romberg was negative.

Assessments
1. Vertigo NOS - 780.4

Treatment
1. Vertigo NOS
Notes: Will obtain ct head result. As the pt is feeling better will f/u prn. Sent message to Miss wanda williams and Pitter Jorelli via e-mail.

Jesus Ricardo Leon # 34916061786/N
11-11 Hazen Street
E. Elmhurst, NY 11370



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